Department of Health and Mental Hygiene
Medical Care Programs Administration
MQ.00
Response to Recommendations

Recommendation 1:

Adopt the following narrative:

Encouraging Healthy Behavior and Proper Utilization of Services: The committees find that the design of Maryland's Medicaid program fails to encourage healthy behavior and discourage inappropriate utilization of care. For example, Maryland Medicaid beneficiaries are far more likely than other residents to make an emergency room visit that does not culminate with an in-patient stay. The committees note that other states are exploring the use of health savings accounts and higher beneficiary cost sharing to change behavior and generate program savings. While the specific reforms proposed elsewhere may not be appropriate for Maryland, the committees encourage the Department of Health and Mental Hygiene (DHMH) to explore potential innovations aimed at changing enrollee behavior. The committees direct DHMH to study methods for rewarding Medicaid enrollees who engage in healthy behaviors; the feasibility of establishing a health savings account through which enrollees can access rewards earned; and the potential impact of additional cost sharing on enrollee health. An analysis of the fiscal implications of the options examined should be included in the study.

Response:

DHMH agrees with the recommendation. The DHMH has been looking into what other states are doing and the impact of the additional cost sharing flexibility created by the budget reconciliation act. DHMH recommends an interim report by June 30, 2006 on its findings for encouraging appropriate utilization of care and healthy behavior, and a final report completed by June 2007.

Recommendation 2:

Reduce funding for contractual employees. The reduction allows for a 20% increase over actual 2005 spending.	*Amount Reduction*
	$61,200 GF
	$88,800 FF

Response:

DHMH disagrees with this recommendation. Actual spending on contractual employees was artificially low due to continued hiring problems related to a freeze in contractual

positions. It is difficult to recruit and retain these employees because of the lack of benefits. Therefore, there is a constant turnover in these positions. This fact combined with lengthy freeze exemption process resulted in low numbers of contractual FTEs during FY 2005. The freeze was lifted in November 2005 and many of the vacant contractual positions have been filled or are close to being filled. If this cut is implemented critical contractual personnel will need to be terminated in FY 07. A number of these contractual employees are also engaged in our TPL efforts. A cut in staff would not be cost effective, as it would likely result in lower TPL collections.

Recommendation 3:

Delete 1.5 vacant positions. Both positions (PINs 079372 and 047854) have been vacant for more than one year.	*Amount Reduction* *$32,658 GF* *$53,284 FF*

Response:

DHMH disagrees with the recommendation to delete PINs 079372 and 047854. PIN 079372 is an Office Services Clerk (50%) assigned to the Office of Operations, Eligibility and Pharmacy's mailroom. DHMH is in the process of recruiting for this position. Unfortunately, in the past year, OOEP underwent a significant turnover in management positions and as a result, there have been voids that have affected recruitment, such as in this case.

PIN 047854, currently classified as a Data Processing Programmer Analyst Lead/Advanced has been in the recruitment process for the past year. DHMH has interviewed on three separate occasions utilizing three different recruitment methods. DHMH is currently in the process of recruitment. DHMH is being faced with implementation of multiple major initiatives that require MMIS system changes now as well as in FY 07. This position is assigned to the Recipient Team, which is involved in every initiative that DHMH implements. Therefore, it is critical that we fill this position to support the Recipient Team. If the decision is made to delete this position, DHMH requests that the associated funding remain. Therefore, this will enable DHMH to secure the services of a contractor to assist in the maintenance of the recipient subsystem.

Recommendation 4:

Add the following language:

All appropriations provided for the program – M00Q01.03 are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

Explanation: *The language restricts funds for Medicaid provider reimbursements to that purpose.*

Response:

DHMH agrees with this recommendation.

Recommendation 5:

Reduce funds to recognize savings from changes in federal law. Federal budget reconciliation legislation enacted in January will produce Medicaid savings by reducing payments to pharmacies, closing loopholes that allow nursing home residents to shelter assets, and changing the start of the penalty period from the date of any below market value asset transfer to the date of Medicaid application.	*Amount Reduction*
	$5,000,000 GF
	$5,000,000 FF

Response:

DHMH disagrees with the recommendation. The majority of DLS' saving estimates are from changes in long-term care eligibility and pharmacy. DHMH does not believe that there will be any significant savings from changes in pharmacy. The reasons are as follows:

- As contained in the federal legislation, changes to the Federal Upper Limit for multi-source drugs (generics) and the reporting of average manufacturer price (AMP) for generics are not expected to significantly reduce expenditures. The State has its own maximum allowable charge limit or MAC list for generics, which is usually lower than federal limits. Also, reimbursement for generic products is not a significant percentage of overall pharmacy expenditures.

- The legislation also requires States to collect rebates for physician administered drugs. Maryland has already been doing this for a number of years.

Separately, DHMH believes that the savings from the eligibility changes will be lower, particularly in the short term. The long-term care eligibility changes will apply only to new applicants. In addition, savings will be offset by increased administrative expenses given the additional resources required to assess eligibility under the new federal policies.

Recommendation 6:

Reduce funds for the employed persons with disabilities program. The reduction still allows the program to expand from serving 470 people in fiscal 2006 to 1,000 people in fiscal 2007.	*Amount Reduction*
	$2,617,575 GF
	$ 58,850 SF
	$2,617,575 FF

Response:

DHMH disagrees with the recommendation. House Bill 630 (Legislative Session 2003) directed DHMH to establish a program for Employed Individuals with Disabilities (Medicaid Buy-In) by July 2005.

In addition, in order for the Employed Individuals with Disabilities to be considered a full Medicaid Buy-In program by the federal government, all eligible individuals who meet the eligibility criteria must be eligible to enroll for benefits in this program. A capped program and subsequent registry for this program would not accomplish this goal. The State estimates that the current funding level in FY07 budget is sufficient to cover an uncapped program and, therefore, qualify as a Medicaid Buy-In program.

Recommendation 7:

Delete enhancement funds for kosher food preparation at nursing homes. The nursing home reimbursement formula already provides funding for meals at the nursing homes. The Department of Health and Mental Hygiene has not provided data demonstrating conclusively that costs associated with kosher food preparation are not already reimbursed through the nursing home formula.	*Amount Reduction* *$250,000 GF* *$250,000 FF*

Response:

DHMH disagrees with the recommendation. For three of the four kosher facilities, Medicaid payments fail to cover costs in the cost centers that include food and food preparation.

DHMH knows that the inadequacy of these payments stems in part from food and food preparation costs, where expenditures for each of the kosher facilities are well above the 75th percentile relative to other facilities. Three are well above the 90th percentile.

Recommendation 8:

Reduce funds for Medbank. The State has provided operating grants to Medbank since fiscal 2002. The amount of the grant has declined gradually reflecting the State's desire for Medbank to become self-sufficient over time. In fiscal 2005, Medicare beneficiaries represented about half of the people receiving assistance in obtaining prescription drugs through Medbank. In fiscal 2007, Medicare eligible individuals will qualify for the Medicare prescription drug benefit and should no longer require Medbank's assistance. As a result, Medbank will serve fewer people and should be able to reduce its operating	*Amount Reduction* *$150,000 GF*

expenses. The reduction still provides Medbank with a $350,000 grant from the State, half the amount provided in fiscal 2006.

Response:

DHMH disagrees with the recommendation. DHMH has been working with MEDBANK so that MEDBANK can achieve financial independence from the State, and grant funding has declined gradually. The State funds have been as follows:

FY 2002	$2.5 million
FY 2003	$2 million
FY 2004	$2 million
FY 2005	$1 million
FY 2006	$700,000
FY 2007	$500,000

It continues to be the DHMH's goal to see the program become self sufficient.

Recommendation 9:

Delete funds for studies. The allowance provides $200,000 to contract for studies. No specific studies are noted in the budget. No funds were expended on this purpose in fiscal 2005, and none were requested for fiscal 2006.	*Amount Reduction* *$ 96,100 GF* *$103,900 FF*

Response:

DHMH disagrees with this recommendation.

Funds are requested to review Long Term Care and Managed Care to identify issues of quality, access and economies of scale; e.g., Pharmacy carve-out. The study would also include the compilation of data as the foundation for future "dashboard" reports. It is essential that these funds be available to engage contractors who will provide us with a different perspective, and fresh insight.

Recommendation 10:

Reduce funds for hospital payments by tightening day limits for adult Medicaid participants. This action will increase savings from Medicaid day limits from $50 million to $60 million. The day limits will generate about the same level of savings as they did in fiscal 2006 and will not impact patient access to care.	*Amount Reduction* *$5,000,000 GF* *$5,000,000 FF*

Response:

DHMH disagrees with the recommendation. The 2005 Joint Chairman's Report instructed the Department to discontinue hospital day limits at the end of FY 06. The Department has taken steps to begin to phase out the day limit policy as has been recommended by the Legislature. With the additional $20 million in the budget, the Department estimated savings of approximately $49 to $50 million. (Some of the monies allocated in the budget to reduce the impact of hospital day limits needs to fund the change that went into effect January 2006. The Department reduced the day limit levels from 100% of the average length of stay to 105% of the average length of stay.

Recommendation 11:

Delete funding for two new positions. These positions were created to implement the specialty care expansion of the new Adult Primary Care Program. Chapter 280, Acts of 2005 required the Department of Health and Mental Hygiene (DHMH) to apply for an amendment to its Primary Care Program waiver to include specialty care services, although it did not require the implementation of those services. DHMH applied for the waiver; however, the Centers for Medicare and Medicaid Services approval is still pending. Furthermore, the 2007 allowance does not include funding to implement the specialty care services.	*Amount Reduction* *$40,721 GF* *$45,919 FF*

Response:

DHMH agrees with this recommendation. If the waiver is approved we will request a deficiency appropriation for these two positions.

Recommendation 12:

Reduce funding for payment error rate measurement eligibility reviews. Fiscal 2007 is the first year the department will fully participate in the Payment Error Rate Measurement Program. The Centers for Medicare and Medicaid Services will require the department to conduct approximately 100 eligibility reviews per month in fiscal 2007. The department had originally estimated $1.2 million to conduct 400 eligibility reviews. The reduction in funding recognizes the savings from conducting 100 eligibility reviews per month vs. 400.	*Amount Reduction* *$165,375 GF* *$172,125 FF*

Response:

DHMH disagrees with the recommendation. The decision on sample size for the eligibility sample has not been made at this time. In a pilot program in fiscal 2005 in which the state participated, the sample size was 100 cases a month for combined Medicaid and MCHP. We expect the sample size to be larger for the ongoing program. DHMH is not fully aware of the costs associated in the implementation of this new program, and will work closely with CMS.

Recommendation 13:

Adopt the following narrative:

Purchasing Prescription Drugs in the Most Cost Effective Manner*: Since the advent of HealthChoice, managed care organizations (MCOs) have been responsible for purchasing most prescription drugs for their enrollees. The State has retained responsibility for purchasing mental health drugs for HealthChoice participants and all prescription drugs for Medicaid enrollees who are not enrolled with an MCO. The decision to include most prescription drugs in the managed care program was made years before the State developed a preferred drug list; pursued supplemental rebates from manufacturers; joined a multi-State purchasing initiative; and significantly reduced pharmacy payment rates. With significant fee-for-service cost containment measures now in place, the State may wish to re-examine the benefits of a prescription drug carve-out. The committees direct the Department of Health and Mental Hygiene to study whether the State could achieve additional savings through a prescription drug carve-out. The department should report its findings to the committees by December 1, 2006.*

Response:

DHMH agrees with the recommendation. DHMH will proceed with the study and analyze whether or not it is more cost effective to carve-out prescription drugs from the benefit package provided by MCOs.

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Response to Issues

Issue 1:

DHMH should comment on the feasibility of obtaining a 50% match on the MCHP Premium population and the projected effect of including the MCHP population in 1115 Waiver on the State's budget neutrality position.

Response:

DHMH plans to submit an 1115 waiver amendment to the Centers for Medicare and Medicaid Services (CMS) to cover the MCHP Premium population (children with family incomes between 200 and 300% of the federal poverty level) under a Medicaid expansion rather than as a separate SCHIP Program. DHMH will ask CMS to waive the cost sharing provisions under Medicaid so that the State can continue to charge families premiums for the program. If approved, this will allow the State to receive a 50% match for the MCHP Premium population when we run out of our SCHIP allotment. At this point, CMS staff have not made a final decision about whether this amendment will have an effect on the HealthChoice budget neutrality calculation.

Issue 2:

DHMH should comment on how well the transition to the new Medicare Part D benefit is progressing for the dual eligibles in Maryland.

Response:

Medicare Part D calls throughout DHMH's two hotlines averaged about 110 calls per day at the beginning of January dropping to an average of 60 calls per day by the end of the month. As indicated in the analysis, the majority of calls pertained to recipients not being recognized for the low-income subsidy and being charged high co-pays. Call center staff continue to work with recipients, pharmacists and the prescription drug plans resolving enrollment, co-pay and formulary issues. In limited cases to ensure recipients receive urgently needed medications, DHMH has paid pharmacies for certain prescriptions.

Due to the random assignment of most recipients into prescription drug plans, DHMH prepared guidance for recipients to assist in selecting a plan that addresses their needs. Due to an injunction filed by one of the prescription drug plans, DHMH was unable to send this information. DHMH is currently working with advocates and other interested

parties in determining how Medicaid/Medicare recipients and other Medicare beneficiaries can be assisted in selecting a prescription drug plan that is best for them.

Issue 3:

DHMH should brief the committees on the implications of the new federal law and any of the options it plans to pursue.

Response:

DHMH has attached a chart which identifies a preliminary analysis of the impact of the new federal law. There are 6 key areas which are mandatory for Maryland to implement. The remainder require statutory approval, and we would not implement without proper authority.

Issue 4:

DLS recommends that DHMH study:

- *methods for encouraging Medicaid enrollees to engage in healthy behaviors;*
- *the potential impact of enhanced cost sharing on enrollee health;*
- *the feasibility of establishing a health savings account through which enrollees can access rewards earned for engaging in healthy behaviors; and*
- *cost sharing approaches that will encourage more appropriate utilization of care.*

DHMH should submit a report on its findings and recommendations to the General Assembly by December 1, 2006. The report should include estimates of the fiscal impact of the recommendations.

Response:

DHMH agrees with the recommendation. DHMH has been looking into what other states are doing in terms of encouraging healthy behaviors and the impact of the additional cost sharing flexibility brought about by the new federal deficit reduction act. These issues will need to be carefully studied given the vulnerable nature of the Medicaid population and the fact that many of the efforts cited in the DLS analysis either have not been implemented or are too recent to have undergone a cost effectiveness analysis.

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Response to Comments

Comment Page 18, Bullet 2:

Program Integrity: Program Integrity combats waste, fraud, and abuse. Only $7 million of savings are reported for the first six months of fiscal 2006. DHMH should be prepared to comment on whether the $34 million in savings assumed in the fiscal 2006 and 2007 budgets is still a reasonable assumption.

Response:

The $34 million goal is very aggressive. Even though fraud, waste and abuse efforts began in FY 2005 there was still a certain amount of ramping up in the first half of FY 2006. Program Integrity filled 13 new PINs in the 2nd Quarter of FY 2006. This staff is still new, and is being trained. In the last half of the year, trained staff will initiate more audits and investigations.

The audits and investigations being conducted are producing results. For example, a project was initiated to review foster care children who have not used services in a certain period of time. After review at local agencies we determined some of these children had left foster care but have not been canceled from Medicaid. The results of that project are being seen in January and February of 2006 and will result in cost avoidance of about $2 million. Savings realized through January 2006 are approximately $11 million.

Another eligibility related project which is being pursued has the potential to generate several million dollars. Efforts to increase the number of referrals to the Medicaid Fraud Control Unit have been successful. The number of cases which are being referred to individual states attorneys in various counties is growing and we expect several of the cases to come to trial in this fiscal year.

Comment Page 20, Bullet 1:

DHMH should brief the committees on the implications for enrollees of the proposed legislation to require Kidney Disease Program (KDP) participants to apply for Medicare Part D drug benefits.

Response:

KDP recipients will have to pay Part D premiums, if they are required to enroll in the Medicare Part D program. However, by paying this premium they will receive extra pharmacy benefits, since Medicare Part D provides coverage for many medications not covered by KDP. Part D premiums in Maryland range from a low of $6.44 to a high of $68.91. This Part D premium is in addition to the Medicare Part B premium that KDP recipients are currently paying to Medicare and the premium that some KDP recipients currently pay directly to the Kidney Disease Program. Individual recipient savings will depend on the Part D plan selected and a recipient's out-of-pocket expenditures for drugs not covered by the KDP.